Connecticut Association of Health Plans

Quality is Our Bottom Line

Insurance Committee Public Hearing

Tuesday, March 7, 2017

Connecticut Association of Health Plans

Testimony regarding

<u>S.B. No. 924</u> (RAISED) AN ACT REQUIRING THAT HEALTH CARRIERS USING THE CONNECTICUT HEALTH INSURANCE EXCHANGE PAY A MINIMUM COMMISSION TO CERTAIN INSURANCE PRODUCERS.

<u>S.B. No. 925</u> (RAISED) AN ACT CONCERNING THE COST OF PRESCRIPTION DRUGS AND VALUE-BASED INSURANCE DESIGN. (INS)

<u>S.B. No. 926</u> (RAISED) AN ACT CONCERNING STOP-LOSS INSURANCE POLICIES FOR HEALTH CARE OR MEDICAL BENEFITS. (INS)

<u>S.B. No. 928</u> (RAISED) AN ACT ESTABLISHING A TASK FORCE TO STUDY METHODS OF DEVELOPING, EXPANDING AND IMPROVING THE INSURANCE INDUSTRY WORKFORCE IN THIS STATE. (INS)

<u>H.B. No. 7184</u> (RAISED) AN ACT REQUIRING HEALTH CARRIERS TO REIMBURSE THE STATE FOR COVERED BENEFITS AND SERVICES PROVIDED UNDER THE DEPARTMENT OF CHILDREN AND FAMILIES' VOLUNTARY SERVICES PROGRAM AND ESTABLISHING A TASK FORCE TO MAXIMIZE REIMBURSEMENTS FOR COVERED BENEFITS AND SERVICES PROVIDED BY STATE AGENCIES.

SB 924 requires Qualified Health Plans (QHPs) that participate on the Exchange to pay broker commissions in an amount to be determined by the Exchange Board. This bill is unnecessary. The Exchange Board voted to require broker commissions at their meeting on February 16th, 2017. Creating a statutory mandate around commissions is ill-advised and ties the state's hands at a time when the future of the ACA is uncertain at best. The Board is the best entity to determine whether the cost of broker commissions is worth the associated increase in premium. It's a balance that may tilt one way or another depending on the year. Anecdotally, we hear that most commissions are paid on renewals. At some point in time, the Board may determine that such commissions are not the wisest use of health care dollars and state statute should not prohibit the Board from deciding that consumers would be better served by their elimination. **<u>We urge the committee's rejection of SB 924.</u>**

SB 925 seeks to establish a number of requirements around prescription drug pricing. While the Association concurs that pharmaceutical prices are out of control and finds certain sections of the bill intriguing, we disagree with the approach taken under sections 2, 3, and 4. Connecticut's health insurers have pioneered value based insurance designs constructing innovative partnerships with large provider groups that focus on total quality of care over fee for service treatment. The results have been promising and providers and insurers have been working together more closely than ever through accountable care arrangements and other similarly structured contracts. Section 2 is simply unnecessary as health plans routinely apply these standards in developing their value based benefit designs today. We question why we need to prescribe specific standards in statute particularly at a time when the future of the Affordable Care Act is uncertain. Furthermore, Connecticut's commercial carriers have been working in good faith over the past two years with the State Innovation Model (SIM) office. The efforts have been collaborative, mostly because the structure has been voluntary. Compelling participation in specific value based design efforts, particularly when commercial carriers have been at the forefront of such, seems capricious and arbitrary.

Section 3 of the bill, which requires that coinsurance, copayments, and deductibles be calculated against the net cost of the drug, fails to take into account the comprehensive nature of health benefit designs and that all the cost sharing provisions factor into the overall premium charged. Health plans are held to strict rate review by the Department of Insurance in developing their plan designs providing assurance that cost sharing charged is appropriate. Insurance costs are merely a reflection of underlying costs. Section 3 does nothing to address the underlying issue of pharmaceutical price gouging.

Section 4 is in direct conflict with the concept of value based insurance design promoted in Section 2 by prescribing exactly how health plans must reimburse providers who administer and handle prescription drugs. This requirement runs completely contrary to the new innovative contracting arrangements that are being undertaken and again does nothing to reduce the underlying cost of pharmaceuticals.

We respectfully urge your rejection of sections 2, 3, and 4 of SB 925.

SB 926 relaxes the standards around the issuance of stop-loss insurance deviating from the recently issued bulletins from the Department of Insurance HC-95 and HC-108. The Association supports the standards as outlined in the current bulletins and considers them important consumer protections. As such, **we respectfully oppose the changes proposed in SB 926 and ask that the committee refrain from moving the bill forward.**

SB 928 establishes a task force to study and develop strategies to develop, expand, and improve the insurance industry workforce in this state. Hartford has long been known as the Insurance Capitol of the world. We have six major health insurers operating in the state Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim and United. With over 30,000 jobs tied to the insurance industry as a whole in the state, it's critical that Connecticut continue to recognize the ongoing importance of investing in the sector as this bill articulates. **The Association commends the introduction of SB 928 and asks that the committee report the bill out favorably.**

HB 7184 requires commercial coverage for programs and services provided by Dept. of Mental Health and Addiction Services, the Department of Children & Families and the Dept. of Developmental Services. Health plans have recently started contracting for many of these intended treatment modalities including in-home based psychiatric services. In addition, at the request of Insurance Department and DCF, the Association has also been working in good faith to develop a reimbursement structure for commercial members served by DCF's well renowned Access Mental Health consultative program for primary care providers. It's important to note, however, that many of the intended services were developed as grant funded programs for the good of the public at-large or specifically for the Medicaid/DCF population. Until recently, health plans had never been asked to participate. However, as the data has indicated that commercial members are availing themselves of such services and the outcomes have proved successful under evidence based analysis, health plans have looked to incorporate the care models into the array of services they cover. Having said that, not all services lend themselves to commercial reimbursement either by virtue of practical implications such as the ability of grant funded programs to bill or even code for such services or by virtue of how the array of services fit within the scope of the ACA, its requirements for the Exchange, and/or the standard for "new" mandates which require reimbursement by the state if enacted. All of these points argue for the latter part of the bill establishing a task force for discussion of these issues as opposed to statutorily mandating specific coverage. **We respectfully request that the committee delete the mandate sections of HB 7184 and move forward with the study alone.**

Thank you for your consideration.